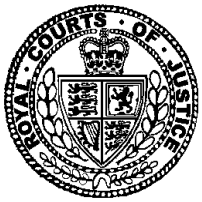

Neutral Citation Number: [2019] EWCA Civ 487

Case No: B3/2018/1275 & B3/2018/1275(B)

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE QUEEN'S BENCH DIVISION
MR JUSTICE MARTIN SPENCER
[2018] EWHC 1225 (QB)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/03/2019

Before :

LORD JUSTICE PATTEN
LORD JUSTICE HAMBLEN
and
LORD JUSTICE HOLROYDE

- -

Between :

Yvonne Lesforis	**Claimant/ Respondent**
- and -	
Christos Tolias	**Defendant/ Appellant**

- -
- -

Grahame Aldous QC (instructed by **Stewarts Solicitors**) for the **Claimant/Respondent**
Philip Havers QC (instructed by **Hempsons Solicitors**) for the **Defendant/Appellant**

Hearing date : 12 March 2019

- -

Approved Judgment

Lord Justice Hamblen :

Introduction

1. The appellant, Mr Christos Tolias, a consultant neurosurgeon, appeals against the decision of Martin Spencer J dated 21 May 2018 whereby, following a trial on liability, it was held that he had been negligent in giving an inappropriately early prescription of antithrombotic medication for the respondent, Mrs Yvonne Lesforis, following spinal surgery.

2. The judge further found that Mr Tolias' negligence caused or at least materially contributed towards the formation of a haematoma leading to compression of Mrs Lesforis' spinal cord which in turn caused or materially contributed to the neurological deficit which she has sadly suffered. This has left her with serious residual and permanent disability in the form of incomplete paraplegia.

3. Mr Tolias sought permission to appeal on eleven different grounds relating to the judge's approach, his findings and his assessment of the expert evidence. Permission was refused by Floyd LJ on all grounds bar one.

4. The sole ground of appeal is that the judge failed directly to address the case that the relevant question was not whether Mr Tolias' practice of routinely giving antithrombotic medication to all his cranial and spinal patients within 6 hours of surgery was a breach of duty, but whether giving such medication to this patient within three hours of surgery was a breach of duty given what were accepted to be three risk factors specifically applicable in her case.

The background facts

5. These are set out in detail in the judgment, [2018] EWHC 1255 (QB) at [4]-[32].

6. In summary (with references to the relevant paragraphs of the judgment), Mrs Lesforis worked as a college lecturer, teaching Health and Social Care and Childcare and Education courses [4].

7. Mrs Lesforis first suffered back pain and sciatica in 2007. She was diagnosed with spondylolisthesis, a condition where an intervertebral disc slips and overlaps with an adjacent disc, thereby narrowing the spinal canal [5]. After a range of treatment was unsuccessful ([5]-[9]), Mrs Lesforis was referred to Mr Tolias at King's College Hospital ("KCH") in 2012 ([9]-[10]).

8. After a number of appointments, Mrs Lesforis decided to undergo decompression surgery on 20 February 2013. She was comprehensively warned of the risks by Mr Tolias and signed a consent form that same day [12].

9. Due to NHS delays, Mrs Lesforis opted to have the operation carried out privately at the Harley Street Clinic where Mr Tolias had a private practice ("the Clinic") [13]. On 27 June 2013, Mrs Lesforis was admitted to the Clinic and signed a further consent form [13]. She underwent spinal surgery at the hands of Mr Tolias, who was assisted by Mr Malik, another consultant neurosurgeon. Other than a minor dural tear which was swiftly dealt with, the operation went smoothly and appeared successful [14].

10. Mrs Lesforis was taken to the Intensive Therapy Unit ("ITU") at 16:11 and at 19:07, about three hours after surgery, she started a course of Low Molecular Weight Heparin ("LMWH"), Clexane, which had been given as a chemo-prophylaxis ("CP") against the formation of deep vein thrombosis ("DVT") [14].

11. Until around midday on Saturday 29 June 2013, Mrs Lesforis' clinical and neurological recovery appeared normal. On 29 June 2013, Mr Tolias ordered that Mrs Lesforis could be mobilised ([15]-[16]). When Mrs Lesforis tried to move she found she was unable to feel her legs or wiggle her toes and had difficulty weight-bearing [17].

12. Mrs Lesforis was seen by another consultant neurosurgeon, Mr Al-Barazi, who was operating at the Clinic that day. Mr Al-Barazi arranged for Mrs Lesforis to have a CT scan of her lumbar spine. An MRI scan was not possible at the Clinic on weekends and the decision was taken not to transfer Mrs Lesforis to a hospital for an MRI ([18]-[19]).

13. The results of the CT scan were surveyed remotely by Dr Connor, a neuroradiologist based at KCH, who considered that there was no compressive haematoma [22]. Mr Tolias started Mrs Lesforis on steroids to try and relieve the inflammation ([24]-[25]). When this made no difference, he decided to operate shortly before midnight on 29 June 2013. Unfortunately, the surgery failed to relieve Mrs Lesforis' neurological deficit.

14. Ms Lesforis was discharged from the Clinic on 16 July 2013. She was admitted to Gravesham Community Hospital and later Stoke Mandeville Hospital for rehabilitation, and was finally discharged on 14 February 2014. She has been left with a denervated bladder and bowel and severely restricted mobility on account of nerve injury affecting her knees and ankles. She is largely wheelchair bound [32].

The judge's decision on liability

15. At the trial, the judge heard evidence from Mrs Lesforis, Mr Tolias, and the other doctors involved on 29 June 2013: Mr Al-Barazi, Dr Connor and Mr Malik (with whom Mr Tolias had originally operated and with whom Mr Tolias discussed the situation on 29 June 2013). He also heard evidence from expert neurosurgeons called for each side, Mr John Leach for Mrs Lesforis and Mr Thomas Cadoux-Hudson for Mr Tolias.

16. The judge found that it was negligent for Mr Tolias to arrange for the administration of CP within six hours of the operation and that causation was made out. He rejected an allegation that it was negligent to delay intervention after 14.30 on 29 June 2013 until surgery at midnight.

17. CP is administered in order to protect against the risk of venous thromboembolism ("VTE") (blood clots forming in the veins leading to DVT). Such drugs, however, increase the risk of a post-operative bleed at the operation site. This can lead to a haematoma (a swelling of clotted blood) forming and bringing pressure to bear on the nerves in the spinal cord at the point where decompression is being attempted. If such a haematoma forms and there is clinical evidence of nerve impingement then it is a medical emergency. If left untreated there is a risk of nerve damage resulting in permanent injury. In outline, that is what happened in this case.

18. The judge addressed the evidence relating to whether the administration of CP within six hours of the operation was negligent at [37]-[53].

19. The judge cited the evidence given by Mr Tolias as to why he had prescribed CP when he did, as set out in the unchallenged evidence in his witness statement [37]:

> "13. At the end of the operation I prescribed subcutaneous Clexane for her once daily. I see that that prescription is criticised and I can only say that it is my invariable routine to give patients anti-coagulation after this sort of operation. An overweight patient such as Mrs Lesforis, particularly one who is going to remain flat for 48 hours after the operation because of the durotomy, is at increased risk of venous thromboembolic events and therefore Clexane is indicated, along with intermittent calf compresses which were also prescribed (in accordance with NICE guidelines). However, it is my normal practice to give anti-DVT chemo-prophylaxis (Clexane) very early post-operatively to all my cranial or spinal patients and I am surprised to see it is criticised in the Letter of Claim."

20. In the light of this evidence, the judge found that Mr Tolias did not discriminate between patients as to the timing of prescribing CP. He prescribed it early post-operatively for all his patients. He did not do so for Mrs Lesforis because of any particular individual circumstance relating to her [33].

21. The judge then cited from the expert report of Mr Leach, noting his evidence that because of the risk of haematoma and compression CP "is not given in the very early post-operative period" following spinal surgery; that doing so within six hours of surgery "increases the risk of post-operative haematoma formation"; that that risk decreases with time such that there is a "much lower risk" if CP is administered 12-24 hours post operatively rather than within six hours, and that in his opinion doing so within six hours "represents a breach of duty" [38].

22. He then referred to the expert report of Mr Cadoux-Hudson in which he said that some neurosurgical and spinal units give CP routinely 12-24 hours after spinal surgery and that it was his practice to do so at 24 hours. The judge commented that:

> "This was hardly a ringing endorsement of Mr Tolias' routine practice to give very early chemo-prophylaxis: indeed, Mr Cadoux-Hudson did not suggest that there was a reasonable body of spinal surgeons in the UK in 2013 who would give chemo-prophylaxis at such an early stage as opposed to 12-24 hours after spinal surgery" [39].

23. The judge addressed the Joint Experts Meeting ("JEM"). In relation to the claimant's agenda the question was asked: "Was it appropriate to prescribe chemo-prophylaxis against venous thromboembolism within six hours of surgery?". In answer to this question it was recorded that Mr Cadoux-Hudson noted that "there are a number of different practices within surgery and particularly within neurosurgery". Mr Leach's answer was that "there is not a reasonable body of spinal surgeons that administers chemo-prophylaxis against VTE within six hours of surgery" [40].

24. In relation to the defendant's agenda, it was agreed that for all surgery "there is a wide range of opinions about the optimal time" to start CP for VTE and that this will depend on "patient risk factors and the type of surgery performed". In answer to question 2.5, it was agreed that Mrs Lesforis was at increased risk of VTE because she was slightly overweight and was expected to be nursed flat for an extended period. The following question and answers were also noted:

> "2.6 Do you agree that there are some spinal surgeons who would have prescribed chemoprophylaxis against venous thromboembolism within 6 hours of surgery?
>
> The experts disagree.
>
> Mr Cadoux-Hudson, as pointed out above, is of the view that chemoprophylaxis is theoretically more effective the closer to the surgery event (best results have been demonstrated if given before surgery). The precise timing is at the surgeon's discretion, weighting the risks and benefits to the patient.
>
> Mr Leach believes that there is not a reasonable body of spinal surgeons that would commence chemoprophylaxis against VTE within 6 hours of major spinal surgery " [41].

25. The judge then addressed the oral evidence given by the experts. He cited the following passages from Mr Leach's cross-examination in answer to the question that the timing of when CP should be given remained unclear and different surgeons would give it at different times:

> "I had to look at the guidelines as they were at the time and look at the evidence and come up with an answer for the court about whether there was a reasonable body of surgeons in the UK – spinal surgeons – who gave early, less than six hours chemo-prophylaxis. It is a treatment that has a potential to cause significant harm, so there would need to be evidence of safety to do it. And on that basis my view is that there is not a reasonable body of surgeons who give chemo-prophylaxis very early after spinal surgery within six hours, because of the risk of haemorrhage. … I'm not aware of a reasonable body of surgeons in the UK who give it pre-operatively and if I'm presented with evidence, for example that there is a protocol at King's College Hospital that all surgeons give it early or I'm presented with evidence that there is a body of surgeons that gives it early, within six hours, then I will accept that is reasonable. But where there is a lack of good clinical evidence and where there are just guidelines I do have to fall back and rely upon experience, having worked in many centres in the UK. I also noted Mr Cadoux-Hudson's statement that he also gives it in a delayed fashion, and I have not been presented within this process of any protocol or suggestion that there is a group of surgeons in the UK that give it within six hours. I will be prepared to alter that opinion if I was presented with evidence to the contrary."

26. In relation to Mr Cadoux-Hudson's evidence, the judge referred to it being put to him in cross-examination that he had not said in his report that he was aware of some surgeons who would routinely give CP within three hours of surgery, to which Mr Cadoux-Hudson had answered: "Unless the surgeon states otherwise" [47]. The judge then summarised the following evidence given (for the first time) in re-examination:

> "In re-examination, Mr Cadoux-Hudson was referred again to his answers at the JEM and he was asked this question:
>
> "In 2013, with a patient who was overweight and who it was intended would spend the next 48 hours lying flat, would giving chemo-prophylaxis three hours post-surgery have fallen within the variation of practice in the UK which you referred to earlier in your evidence?"
>
> To which Mr Cadoux-Hudson answered:
>
> "Yes it would. Yes. "
>
> He also agreed with the proposition that if a surgeon took the view that a patient who is overweight and would be lying flat for the next 48 hours should have chemo- prophylaxis three hours following surgery that would be a reasonable view for the surgeon to take. In answer to a question from the court, Mr Cadoux-Hudson said that there were surgeons in 2013 who had a system of giving LMWH on the evening of their surgery even if the surgery ended in the afternoon" [49].

27. Having summarised the main arguments of counsel the judge addressed the evidence and arguments under the heading "Discussion". He observed that resolution of the issue "depends principally upon my assessment of the respective experts" and that on this issue he preferred the evidence of Mr Leach to that of Mr Cadoux-Hudson [54]. He noted that Mr Cadoux-Hudson had not given any evidence that there is a body of surgeons who routinely give CP after spinal surgery within six hours, although this would have been an obvious way to refute the allegation of negligence. He accepted "Mr Leach's evidence that he is not aware of spinal surgeons in the UK who, in 2013, were giving chemo-prophylaxis as early as within six hours of surgery" and concluded that "this is likely to be because there was no such body of surgeons" [54].

28. The judge referred to the evidence of Mr Tolias, noting his evidence that he gave CP early to all his spinal patients rather than because of any specific assessment of this particular patient, observing that [55]:

> "…this raises a serious question about the practice of Mr Tolias in this regard: the experts agreed that, in relation to all surgery, the timing of prophylaxis against VTE will depend on patient risk factors for VTE and bleeding risk of surgery. The giving of very early prophylaxis to all such patients does not take into account the individual factors which need to be taken into account."

The judge found that it was for this reason that Mr Cadoux-Hudson had speculated that there would have been a discussion about this between Mr Tolias, Mr Malik and the anaesthetist, but there was none. He then noted Mr Cadoux-Hudson's failure to state in the JEM that he was aware of neurosurgical units who routinely administered CP within six hours of spinal surgery, despite the specific questions asked [55].

29. The judge accepted that Mr Leach's evidence that it represents a breach of duty to prescribe CP against VTE within six hours of surgery amounted to saying that the giving of very early CP "falls below the reasonable standard according to the "Bolam" test" [56].

30. He then addressed and answered the main arguments advanced by Mr Philip Havers QC for Mr Tolias as follows [56(i)-(v)]:

(i) In 2013 there was no consensus among spinal surgeons as to when chemo-prophylaxis should be given in terms of timing post-operatively but there was a disparate range of practice;

> "Although I accept that there was quite a disparate range of practice across the UK in relation to the timing of the giving of chemo-prophylaxis after spinal surgery, in my judgment this range will have been within the period 24 hours to 48 hours post-surgery or perhaps 12 hours to 48 hours post-surgery but not within six hours of surgery. Thus, whilst I accept that there was no consensus amongst spinal surgeons in the UK in 2013 as to when chemo-prophylaxis should be given in terms of timing post-operatively, I do not accept that there was no such consensus as to when chemo-prophylaxis should not be given. I accept Mr Leach's evidence that no reasonable body of spinal surgeons in 2013 would have given chemo-prophylaxis routinely within six hours of spinal surgery in 2013. To give such early chemo-prophylaxis required specific justification in the specific circumstances of the case having weighed the risks and benefits of so doing."

(ii) Mr Cadoux-Hudson said that he was aware of surgeons who have given chemo-prophylaxis within six hours;

> "Although Mr Cadoux-Hudson stated that he was aware of surgeons who gave chemo-prophylaxis within six hours, I do not accept that evidence: had he been so aware, I consider he would have said so much earlier than re-examination, probably in his report and certainly in the course of his discussion at the JEM with Mr Leach."

(iii) The NICE guidelines current at the time of this operation were silent as to the timing of chemo-prophylaxis;

> "It is true that the guidelines current in 2013 said nothing about the timing of giving of chemo-prophylaxis after spinal surgery. The 2018 guidelines do and suggest that, for routine chemo-prophylaxis, the appropriate time period is 24 – 48 hours after surgery (which accords with the practice of both Mr Leach

> and Mr Cadoux-Hudson). These guidelines are likely to reflect the practice that was common in the UK in the year or so before their publication, that is in 2016/2017. In my judgment, it is extremely unlikely that practice in the UK in 2013 was significantly different. If anything, the movement after 2013 was towards giving chemo-prophylaxis to more patients and sooner, that is a liberalisation of practice in the UK, and for these reasons the 2018 NICE guidelines are of some help."

(iv) Mrs Lesforis had specific risk factors for VTE;

> "I accept that there were three risks factors for VTE in the Claimant's specific case, namely that she was overweight, she was expected to be immobile for 48 hours post-operatively and that her anaesthetic and surgery time had exceeded 90 minutes. However, these were reasons for giving the Claimant post-operative chemo-prophylaxis against VTE: they do not speak to the timing of the prophylaxis."

(v) Mr Cadoux-Hudson stated that to give chemo-prophylaxis to such a patient three hours following spinal surgery in the UK in 2013 would have fallen within the variation of practice to which he referred;

> "In so far as Mr Cadoux-Hudson stated that, in his view, the giving of chemo-prophylaxis to a patient such as the Claimant within three hours would have fallen within the variation in practice to which he referred and would have been reasonable, I do not accept that evidence but I prefer the evidence of Mr Leach in that regard."

31. In the light of these findings, the judge concluded as follows [57]:

> "For the reasons stated above, in my judgment it was negligent for Mr Tolias to have prescribed chemo-prophylaxis for all his cranial and lumbar patients routinely within six hours of surgery and it was negligent for him to have done so specifically for Mrs Lesforis. Mr Tolias did not explain in his witness statement the origin of this practice and that again was a surprising omission. I find that his use of LMWH after spinal surgery was cavalier, and outside the range of normal practice at the relevant time."

The appeal

32. In support of the sole ground of appeal Mr Havers submits that, although the judge accepted the three risk factors for VTE in Mrs Lesforis' specific case, he dismissed them as irrelevant to the timing of the administration of CP (at [56(iv)]). In doing so, he failed, both here and generally, to have sufficient regard to the underlying clinical judgment to be made as to striking a balance between the risks and benefits of giving CP within six hours of surgery. He therefore failed to address the relevant underlying question, which was whether Mrs Lesforis had shown that in her case the risks of giving CP within six hours of surgery outweighed the benefits of doing so.

33. The three risk factors in Mrs Lesforis' case were that (i) she was overweight, (ii) she was to remain flat for 48 hours post-operatively and (iii) the operation had lasted for more than 1½ hours.

34. Mr Havers stresses that both the evidence of Mr Leach and the judgment focuses on the general question of when CP should or should not be routinely administered. It does not clearly or sufficiently address the specific question of when it may have been appropriate to do so with regard to Mrs Lesforis, given the three risk factors identified. In this connection Mr Havers QC highlights various passages in the judgment which refer to "routine" or "routinely" in relation to the giving of CP. In particular, he relies on the following passage from [56(i)]:

> "I accept Mr Leach's evidence that no reasonable body of spinal surgeons in 2013 would have given chemo-prophylaxis routinely within six hours of spinal surgery in 2013. To give such early chemo-prophylaxis required specific justification in the specific circumstances of the case having weighed the risks and benefits of so doing."

35. Mr Havers submits that this shows recognition that the correct question is whether there was a specific justification in the specific circumstances of the case to give CP within six hours of surgery, but that this question is not then answered by reference to Mrs Lesforis and her three risk factors.

36. Although Mr Tolias did not carry out a specific risk and benefit assessment with regard to Mrs Lesforis, but simply followed his normal practice in relation to the administration of CP, it is submitted that this would only involve a breach of duty if the giving of CP within six hours would have been negligent following such an analysis.

37. In summary, the judge did not address or answer the relevant question. Nor, it is submitted, did Mr Leach. It is said that Mr Leach's evidence does not support a finding of negligence in relation to the relevant question and that the appeal should therefore be allowed rather than the case remitted.

38. In my judgment there are a number of answers to the appeal, despite the cogency with which Mr Havers presents it.

39. First, it is apparent that the judge did address and make findings in relation to the relevance of the three risk factors. At 56(iv) he specifically found that these factors "were reasons for giving the Claimant post-operative chemo-prophylaxis against VTE: they do not speak to the timing of the prophylaxis". On the basis of that finding they provided no reason to depart from what was found to be routine safe practice in relation to timing.

40. Mr Havers sought to attack that finding, submitting that it was not borne out by the transcript of evidence and that it was inconsistent with the experts' general agreement that timing depends on patient risk factors. It is doubtful that this is open to him given the limited permission granted, but I shall nevertheless address the points made.

41. The relevant part of the transcript of evidence is as follows:

"Page 158
Q. Of course, in this particular case there were two specific risk factors for this patient, weren't there? You have agreed that in your joint statement. First of all, she was overweight?
A. I am just wondering if there are three actually: She was overweight; she had an anaesthetic or surgery time of greater than 90 minutes; and she was expected to have post-operative immobility. And I do accept that for this patient there were risk factors for venous thromboembolism, yes.
Q. And of course the protection provided by chemoprophylaxis simply doesn't kick in until you start giving it?
A. Well, you give mechanical prophylaxis immediately,
Page 159
starting with stockings applied before theatre, then calf pump boots during the operation, so that protection is given. But I think your question is referring to when the drug starts working: it does only start working after it is administered.
Q. Yes, of course. So the fact that she had no less than three risk factors for VTE would militate – would support giving chemoprophylaxis sooner rather than later?
A. No, it would support the use of chemoprophylaxis. I think we have covered the issue of timing in some detail. That is what is at issue, in my opinion: what is appropriate timing?
I do accept that a surgeon acting responsibly would prescribe chemoprophylaxis for this patient.
Q. And if there are three additional risk factors, those risk factors will operate, or may operate, to give rise to VTE from the outset unless and until they are countered by not only mechanical but also chemoprophylaxis?
A. Yes, there is a time of risk between the end of the operation and when you start chemoprophylaxis. That is exactly the point, that there is a balance of judgment. Because there is a judgment between on the one hand a catastrophic neurological outcome from an epidural
Page 160
haematoma, versus the possibility of a pulmonary embolism. And that is precisely the point, there is a risk either way.
If the patient did not have risk factors for venous thromboembolism, if it was a thin patient having a short operation with early mobilisation, then probably they would not need chemoprophylaxis."

42. Mr Havers submits that, considering this passage of evidence as a whole, there is no clear rejection of the relevance of the three risk factors to timing and that Mr Leach is accepting that it gives rise to a balance of judgment.

43. In my judgment Mr Leach's evidence is clear. At page 159, lines 6-9 it was specifically put to Mr Leach that the three risk factors would support giving CP earlier and his answer was – "No". That answer was not further questioned or challenged. Mr Leach then explained that in his opinion these factors went to the issue of use of CP rather than its timing.

44. On any view, it was open to the judge to draw the conclusion he did from the evidence given. What inferences it is proper to draw from oral evidence is very much a matter for the trial judge who hears the evidence, sees the witnesses and is best placed to understand the context.

45. Nor do I accept that this conclusion was somehow not open to the judge because it was inconsistent with other evidence. The agreed evidence in the JEM about the relevance of patient risk factors to timing was expressed in general terms. The oral evidence was specific to the three relevant risk factors in this case, one of which had just been identified by Mr Leach himself, bearing out the judge's conclusion that he was a fair-minded witness. Even if there was an inconsistency, that would be a matter for the judge to resolve as he sought fit.

46. Secondly, even if one was to accept that the risk factors were relevant to timing, that would not detract from Mr Leach's clear and consistent evidence that giving CP less than six hours after surgery was a breach of duty. It seems clear that he maintained that view notwithstanding the identification of the relevant risk factors. These were first identified in answer 2.5 to the defendant's JEM agenda, which was immediately followed by answer 2.6 cited above, which sets out Mr Leach's view that, notwithstanding the answer just given, "there is not a reasonable body of spinal surgeons that would commence chemoprophylaxis against VTE within 6 hours of major spinal surgery". This is also reflected in the excerpts from the oral evidence cited above, where Mr Leach refers at page 159, lines 11-13 to the "issue of timing" and what is "appropriate timing", issues that had already been "covered". In other words, these risk factors did not affect Mr Leach's repeated view that giving CP less than six hours after surgery was unsafe practice and a breach of duty.

47. Further, in so far as Mr Cadoux-Hudson may be said to have given contrary evidence in answer to directional questions in re-examination, the judge rejected that evidence [56(ii) and (v)]. The judge was clearly and understandably unimpressed by the fact that such evidence was being put forward for the first time in re-examination. In any event, at best Mr Cadoux-Hudson's evidence was that in his opinion giving CP three hours after surgery to a patient with the relevant risk factor would be reasonable. He did not give any evidence that this reflected the acceptable practice or view of a reasonable body of surgeons.

48. Thirdly, I do not agree that the judge addressed the wrong question. On the judge's findings the three risk factors did not justify any departure from what he found to be the routine safe practice. It was therefore understandable that he should make findings by reference to what was "routine". Equally, when the judge referred to the fact that there might be specific justification in the specific circumstances of a case for giving

CP within six hours of surgery, he was clearly referring to circumstances other than the three risk factors. He did not address the specific question he there posed because, in the light of the findings he made, it did not arise in this case.

49. Fourthly, although it may not be determinative of the appeal, it is a striking feature of this case that Mr Tolias gave no evidence seeking to explain or justify the giving of CP to Mrs Lesforis three hours after surgery, other than by reference to his normal practice. He did not carry out the risk and benefit assessment which it is contended should have been carried out, nor did he give evidence that if he had carried out such an assessment that would have led him to the conclusion that early administration of CP was appropriate.

50. It is also a striking feature of this case that Mr Cadoux-Hudson gave no evidence in his reports, in the JEM, in evidence in chief or in cross-examination that he was aware of surgeons who gave CP within six hours of spinal surgery. The first suggestion to that effect was made in re-examination, which evidence the judge rejected.

51. The reality is that the refusal of permission to appeal in relation to all the other grounds leaves Mr Havers with little ammunition to deploy on his sole remaining ground. In particular, it is not open to him to seek to challenge the findings made by the judge or his analysis and rejection of Mr Cadoux-Hudson's evidence.

52. For all these reasons I would dismiss the appeal. For completeness, it should be noted that Mr Tolias has an application to adduce further evidence. Realistically, Mr Havers accepted that the further evidence is only relevant if the matter was remitted and did not seek to pursue the application for the purposes of the appeal. It is of no relevance one way or the other to the issues on appeal.

Conclusion

53. For the reasons outlined above, I would dismiss the appeal.

Lord Justice Holroyde:

54. I agree.

Lord Justice Patten:

55. I also agree.